**State of Tennessee**
**Health Services and Development Agency**
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
**www.tn.gov/hsda** Phone: 615-741-2364/Fax: 615-741-9884

# NOTICE OF REPLACEMENT AND/OR UPGRADE OF MAJOR MEDICAL EQUIPMENT

TCA §68-11-1607(a)(6), requires that notification be made to the Tennessee Health Services and Development Agency of the replacement and/or upgrade of any major medical equipment that would not require an additional Certificate of Need. Such notification shall be made prior to acquisition of such equipment. PLEASE NOTE that a separate form is to be used for each type of equipment for which notification is being provided.

Should you wish to provide information not specifically requested or further information with regard to information reported, please attach a separate page to provide such narrative.

□ **Cardiac Catheterization** □ **Computerized Axial Tomography**

□ **Linear Accelerator/Cyberknife/Gamma Knife**

□ **Magnetic Resonance Imaging** □ **Positron Emission Tomography**

□ **Other (Describe):** _____

□ **Replacement with Upgraded Equipment** □ **Replaced Equipment with Same Type**

□ **Upgraded Software Only**

## NAME AND ADDRESS OF PROVIDER

_____
(Name)

_____ _____
(Street Address) (County)

_____
(Mailing Address, if different from Street Address)

_____ _____
(City) (State) (Zip) (Telephone Number)

## CONTACT PERSON OR AUTHORIZED AGENT SUBMITTING FORM

_____ _____
(Name) (Title)

_____ _____
(Company) (Telephone Number)

_____
(Mailing Address) (City) (State) (Zip)

## A. Original Equipment Information

**Brand Name:** _____

**Type of Equipment (ex.: 64 Slice CT)** _____

**Date Equipment Acquired:** _____ **Other Information (ex.: Serial Number):** _____

**Cost of Equipment:** _____ **Expected Useful Life (years):** _____

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## B. Replacement/Upgraded Equipment Information

**Brand Name:** _____

**Type of Equipment (ex.: 64 Slice CT)** _____

**Software Upgrade Enhancements: (If software only)** _____

**Date Equipment Acquired:** _____ **Other Information (ex.: Serial Number):** _____

**Owned or Leased:** _____ **Leased By Whom:** _____

**Fixed or Mobile Unit:** _____ **Number of Days Per Week If Mobile:** _____

**Cost of Equipment:** _____ **Expected Useful Life (yrs):** _____

I hereby certify that this information is true to the best of my knowledge, information and belief, and that supplemental written notification will be filed with the Tennessee Health Services and Development Agency in the event of any change in the information given in this report.

Signature _____ Date _____